

**MODULE 2 - LABOR AND DELIVERY**

1. WAS THE WOMAN TRANSFERRED FROM ANOTHER FACILITY PRIOR TO ADMISSION TO LABOR AND DELIVERY?
- ☐
- Yes
- ☐
- No

IF YES, FACILITY NAME AND LOCATION TRANSFERRED **FROM**:

2. Facility Name: \_\_\_\_\_

3. City/Town: \_\_\_\_\_

4. County: \_\_\_\_\_

5. OBSTETRIC PROCEDURES (CONTINUED) DURING LABOR AND/OR DELIVERY (Check all that apply)

## FETAL MONITORING

06 ☐ Auscultation07 ☐ External Electronic08 ☐ Internal Electronic

## INTERVENTION OF LABOR

09 ☐ Tocolysis10 ☐ Stimulation of Labor11 ☐ Induction of Labor12 ☐ Episiotomy13 ☐ Other, specify: \_\_\_\_\_15 ☐ Unknown00 ☐ None

6. TYPE OF ANESTHETIC (Check all that apply)

01 ☐ Inhalation02 ☐ Epidural03 ☐ Spinal04 ☐ Local05 ☐ Pudendal06 ☐ Other, specify: \_\_\_\_\_00 ☐ None

NAME OF ANESTHESIOLOGIST:

(Last Name)

(First Name)

(MI)

7. COMPLICATIONS OF LABOR AND DELIVERY (Check all that apply)

01 ☐ Abruptio Placenta02 ☐ Anesthetic Complications03 ☐ Arrested Progress04 ☐ Breech/Malpresentation05 ☐ Cephalopelvic Disproportion06 ☐ Cord Complications07 ☐ Cord Prolapse08 ☐ Dysfunctional Labor09 ☐ Excessive Bleeding10 ☐ Fetal Distress11 ☐ Fever >100° F or 38° C12 ☐ Intrapartum Infection13 ☐ Lacerations with Hemorrhage14 ☐ Lacerations without Hemorrhage15 ☐ Maternal Death16 ☐ Meconium Moderate/Heavy17 ☐ Non-Reassuring Fetal Heart Pattern18 ☐ Placenta Previa19 ☐ Precipitous Labor <3 Hours20 ☐ Premature Rupture of Membranes >12 Hours21 ☐ Preterm Rupture of Membranes22 ☐ Prolonged Labor (20 Hours)23 ☐ Rupture of Membranes >24 Hours24 ☐ Ruptured Uterus25 ☐ Seizures During Labor26 ☐ Shoulder Dystocia27 ☐ Uterine Atony28 ☐ Other, Specify: \_\_\_\_\_29 ☐ Unknown00 ☐ None

8. LENGTH OF LABOR

Hours

9. WAS A HYSTERECTOMY PERFORMED AT THE SAME TIME?

☐ Yes☐ No

10. MATERNAL BLOOD LOSS

cc

**PAYER INFORMATION**

11. MOTHER'S INSURANCE INFORMATION

a. Company Name: \_\_\_\_\_

b. Policy Number: \_\_\_\_\_

Name of Individual Completing This Module

Signature

Date